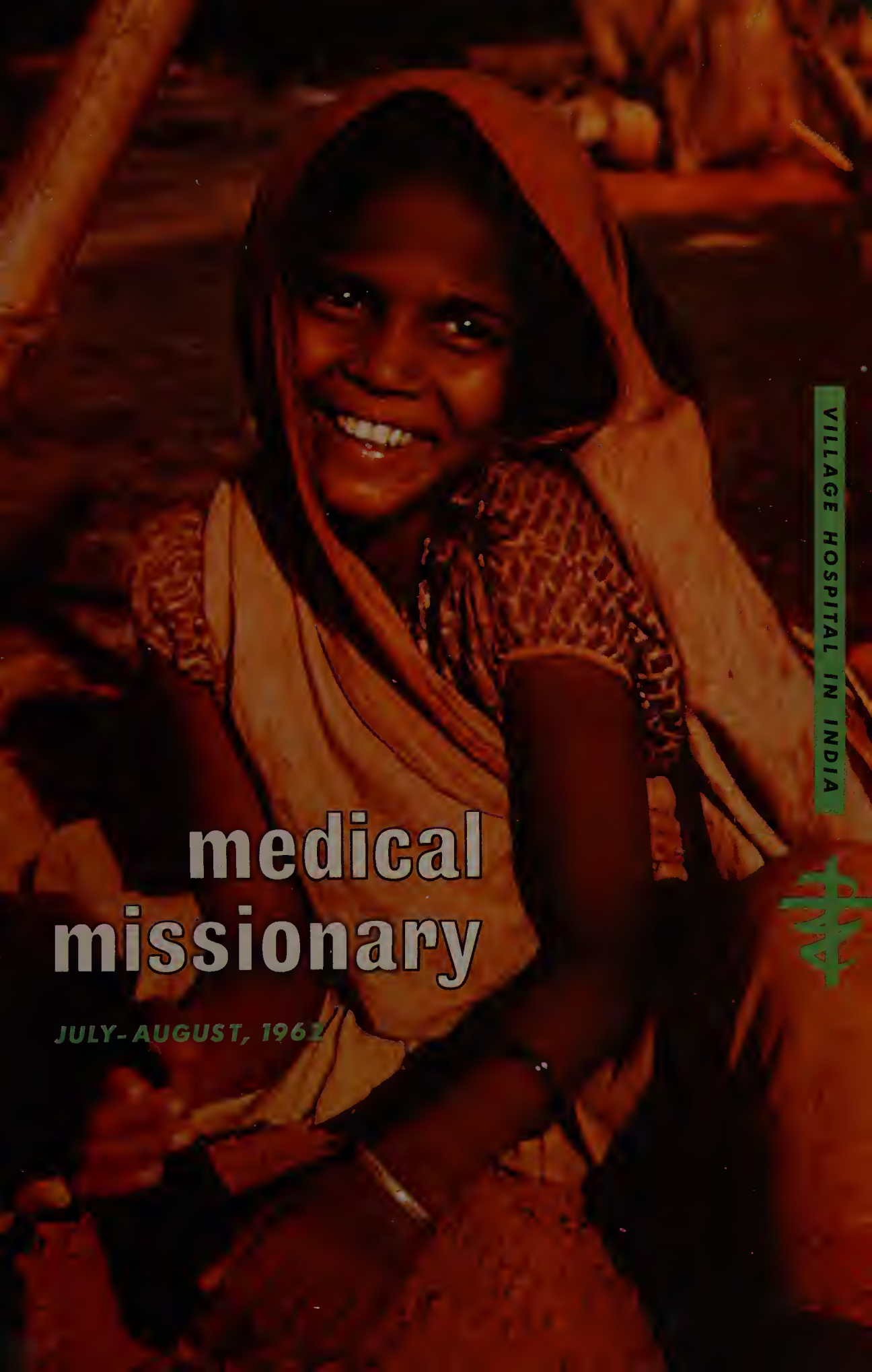

VILLAGE HOSPITAL IN INDIA

medical missionary

JULY-AUGUST, 1962

Mary in the Fathers of the Church
fourth in a series
ASSUMPTION OF MARY

The virginal body which received God could not be imprisoned in the hollows of the earth. This completely holy dwelling place of God must be completely free from dissolution into dust. She who brought heaven into our dust, now brings our dust into heaven. She who gave life to Life migrates up to a new life, to the place where life originates and life is indestructible. We congratulate her as she rises in that same human body that bore the Only-begotten. In her Assumption we celebrate the embodiment of God's plan for redeemed humanity, and we see realized in its perfection our own and the Church's glorious destiny. For to this end did the God of heaven appear on earth as a lowly man, to draw man heavenward. So let us be pilgrims in this world by fixing our hearts in heaven. Let us glorify and bear God in our bodies while passing over the stormy sea of this world, so that we may attain together with the Mother of God, the happy haven of paradise.

compiled from patristic sources.

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Cover Photo

Hindu girl, Kodarma, Bihar, India

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EDITOR: Sr. M. Angelica; Business: Sr. M. Kevin; Art Sr. M. Lawrence, Frank X. Smith

Birth of a

THE history of Holy Family Hospital, Kodarma goes back to some visits that the Rev. Father De Meulder, S.J., made to the mica mines' area of Bihar. He encouraged one of the Hindu mica merchants, Mr. Samonta, to give land for the hospital, and anyone who knows Father De Meulder will understand how persuasive he can be. Land was readily given as well as help with making bricks, hauling material and advice.

In 1955 the Sisters from Holy Family Hospital, Mandar, were sent, two at a time, to take turns watching the construction, sewing sheets and other linen, and getting acquainted with the people. One of the Australian Jesuit Fathers came to supervise the building. A one-room dispensary was begun almost immediately and the villagers came from all directions. Gradually as the building was completed, a room was set up with three beds for in-patients, one small room for private patients, one for minor operations, and another one as nurses' duty room.

The people waited on the verandah, squatting on the floor. Some of the old ladies (patients) came prepared for work with their basket of mica to be split into minute slices with a very sharp pointed knife. The factories send small baskets of mica to the villagers' homes so the whole family can work on it and return the finished product each morning. It is weighed and the people are paid accordingly. It was a worthwhile pastime for them as they waited to see the doctor.

There was a very simple little Chapel which was filled for daily Mass, not only with the few Sisters and nurses, but also, the Uraon coolies, carpenters, and masons working on the building. Even today our Chapel serves as the parish church. It was a real experience to hear them singing the Hindi hymns so vehemently. Some of the workmen had come from Mandar where they had learned their trades from the Jesuits.

The main hospital building was begun in 1955 and completed in July, 1956. It took a long time with many, many difficulties, such as running back and forth to Hazaribagh, getting cement and dynamite permits; bringing supplies, fixtures, etc. from Calcutta, 400 miles away; no running water; hauling bricks and sand; labor diffi-

Sr. M. Rupert, M.D. makes a sick call in a village near Kodarma Holy Family Hospital. The people were very happy to see Sister.

Hospital...

SISTER M. CHARLES

Holy Family Hospital, Kodarma in the Mica District of India. 80% of the world's mica is mined here. It is mined in both closed and open mines. Greater Kodarma, and surrounding villages have a population of about 200,000. The people are mostly rice farmers and mica miners.

culties and all the rest that can be imagined. But it was most challenging. The nurses were graduates from our training schools in Patna and Mandar. There was a very small compact Out-Patient Department, two large 7-bed wards. four private 3-bed wards, nurses' stations and large O.R.

Patients soon spread the word and all the difficult delivery cases poured in as well as a fair number of normal ones. We barely got a bed empty when someone else was begging to be admitted. Everyone was anemic from hookworm and nutritional deficiencies, especially the women, and many of the delivery patients arrived with 3 and 4 Gm. (15 to 20%) hemoglobins—their tongues sheet-white and conjunctiva, just gray. I don't know how these women live with these unreadable hemoglobins. What surprised us most was that these very sick ones recovered and responded well to hematinic therapy. We had no blood banks and donors were very few. Many times glucose and saline had to do, and sometimes life ebbed away but more often, slowly revived. Some relatives actually went to Calcutta and brought back whole blood for transfusions, but not many could afford that!

Our hospital was situated between a Moslem village (Lakibagi) and a Hindu village (Chechai). There were many other villages surrounding us but we could not see them. We were surrounded by red, red, dry soil, except in monsoon time, when everything looked green. One day when we had cycled out to a village a few miles away, we were invited into a big mud hut where all the children of the village had assembled. They proceeded to sit down

Most of the patients had anemia from hookworm and other nutritional deficiencies, especially the women; many arrived with hemoglobins of three or four grams (15 to 20%). How could these women go on living with those unreadable hemoglobins?

on the mud floor, while we sat on a *charpoi* (a low string bed). The teacher immediately produced two rusty chairs for us to sit on. When we laughingly refused and said we were quite comfortable on the *charpoi*, they seemed very happy that we didn't prefer those American gadgets after all.

Kodarma is a mine area. There was a great deal of T.B., pulmonary fibrosis, and other chest diseases. Eosinophilia often was found. We treated a great deal through the Out-Patient Department. The babies admitted were usually dehydrated and run down with nutritional deficiencies. The mothers were taught to wean the babies early, and a good diet was introduced while in the hospital. It was encouraging to see those babies return to the Out-Patient Department later, much improved. It was always a struggle, however, to convince the mother that suji, eggs, and milk were good for a one year old baby. Malaria and typhoid were quite common, also smallpox in season. During one smallpox epidemic in Chechai many young girls died. The boys didn't get the disease . . . they attended the village school and had been vaccinated there.

Operations soon increased at the hospital as word spread for miles around that there was a good Sister-surgeon (Sister M. Rupert, M.D.) at Holy Family Hospital. They were also attracted by the fact that there was a laboratory technician. They love these tests and place a great deal of importance in them. Needless to say, we do, too, and we were very happy when Sister F. Maria, a medical technologist arrived in 1957.

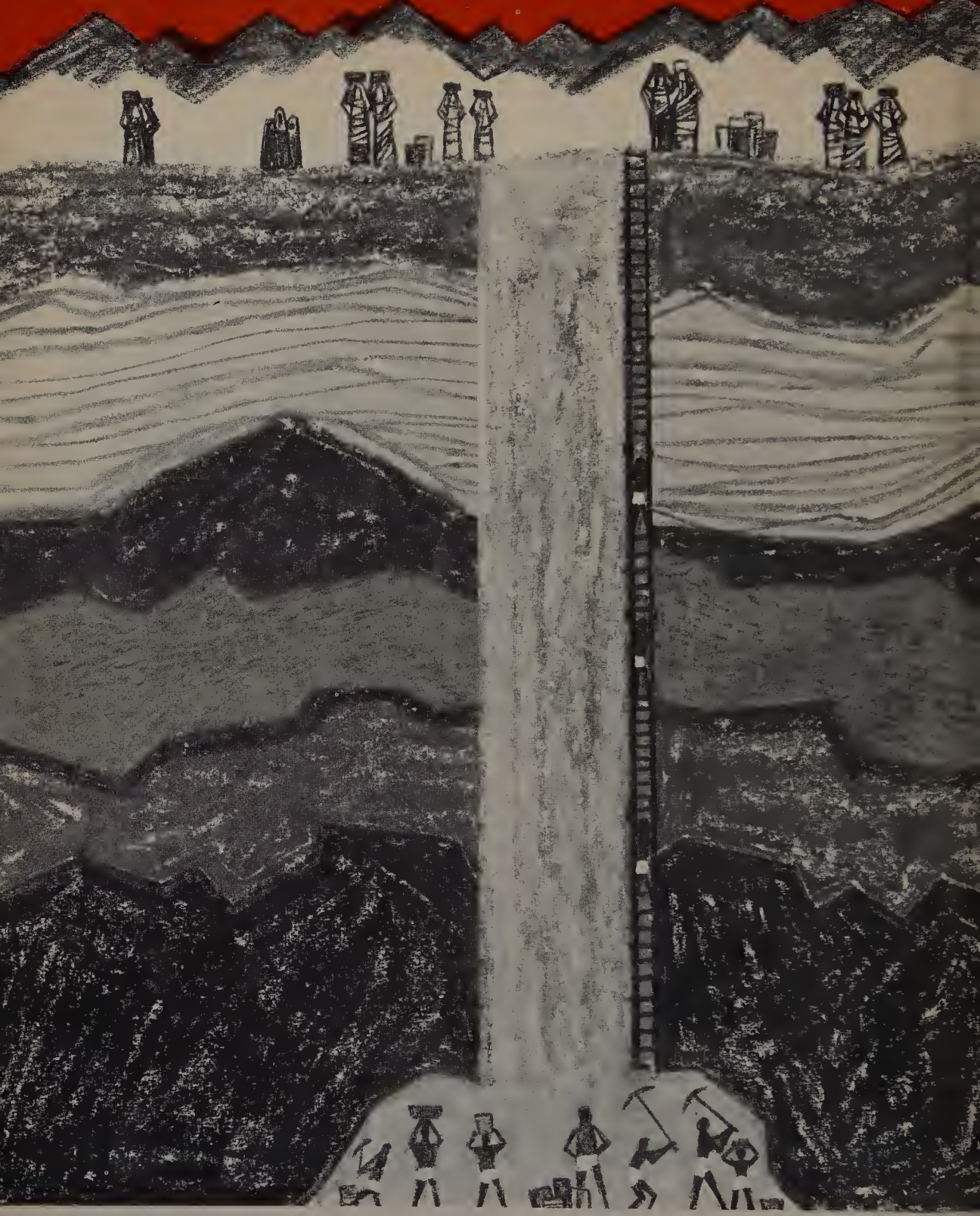
The land is all rock with lots of mica bits all over reflecting in the sunlight

and even in the moonlight! To make any kind of garden we had to dig up the rocks using them to border the plots, and haul in sufficient black earth and manure by truck and jeep trailer. Trees were donated by the Jesuits in Hazaribagh and friends in Ranchi. There was not one shade tree near the hospital when we arrived. There were only two on the whole 12 acres, some distance away. Roads had to be made and even a bridge. A new well had to be dug through the rock, going down 44 ft. with dynamite, picks, and chisels —all hand labor. It took months to dig. Soon beautiful flowers of every description transformed the dry earth. One coolie used to stand and look at the portulaca and sigh and say, "Sister ji—it makes me feel good just to look at these." He had worked hard for the garden so he was very proud of it. We had a few vegetables and some papaya fruit trees also. The many trees we planted had much to overcome: the tropical sun at 110 to 116 degrees, very little water, terrific downpours during the few monsoon months, the cows and goats eating their roots; the sturdy ones survived. Today you would not recognize the place with its beautiful gardens and shade trees of many varieties.

It is always interesting to visit the mica mines which are hidden in the low brush jungle all around. The mica is transported in gunny bags to the factories by jeep and trucks where it is processed and sold. In the factories men and women sit in silence all day splitting, shaping, trimming, and packing. Although the mine workers had some hospital facilities before we arrived, the factory workers and their families had none. They are very grateful for a place to come to for their health needs and we are grateful to be there—a handful of seed in the midst of dry land.

Sister M. Charles supervises a student nurse in the giving of medicine. Sister M. Charles, from Dubuque, Iowa, has worked in India the past 8 years.

Miner at work with pneumatic drill, easing out mica sheets imbedded in the hard rock of the open quarry.



MICA
Doesn't Grow on
TREES

SISTER M. PASCAL

Mica doesn't grow on trees, it has to be mined, blasted, and hacked out of the rock in which it is found. Such work at best is hazardous to health.

IT was early Saturday morning as we two Sisters and three nurses climbed into the waiting jeep. The sky was its usual dark blue, the most beautiful blue that I have ever seen. As we headed for the jungle the cool morning breeze was a treat for it carried the fragrance of the budding cotton and mango trees. In the distance the mountains near Talaya Dam could be seen watching their small children—our Kodarma hills.

Such a beautiful morning, and in another half hour we would exchange it for the strange sight of the dark underground passages of a mine. But such thoughts were soon bumped out of our heads as the road leading to the mine hardly deserves the name "road" as it is a fodder-strewn cow track. Only a jeep could endure such punishment. The mine owner laughed and told us that it would be impossible for an ordinary car. So hanging on for dear life we plunged head long down dry river banks and up sandy hillsides. Suddenly there we were! Not more than 2,200 feet of clearing in the jungle—and here is a mine. About two hundred feet from the pit was the area of the workers' huts, beyond that was the tool shed area. Such a small space, and yet beneath our feet in the mother rock was mica, that could pay for the erection and complete furnishing of a 500-bed modern hospital!

The mine owner took us over to the mine entrance which was about six feet by seven feet. While we were waiting for the iron grating to be unlocked and opened, I looked at the nurses who were nervously eyeing the dark hole in the ground. I must admit that I felt a bit uneasy when I saw the bamboo hand guide on the pit wall. I am much heavier and taller than the average Bihari and past experiences on bamboo ladders have given me the sensation of bouncing on a diving board.

The uneasy feeling was interrupted by the arrival of the guard who broke the seal and unlocked the pit grating. We were all given a candle and told to follow our friend as he would lead the way. Sister F. Maria played the rear guard as she is an old hand at these mining excursions.

So with prayers to our guardian angels and a last fond look at the sun, we began to climb down the ladder, which, much to my relief, was made of logs with only a guide rail of bamboo.

Halfway down the 50 foot shaft we stopped on a platform to light our candles to dispel the ever enclosing darkness. A little more exercise and we were down to the small damp center chamber which branched off into four tunnels. In the soft dirt areas heavy boards and planks supported the roof and walls, but these were few as most of the mine is in a hard rock bed.

Down a dark tunnel that began to dance with the shadows cast by our candlelight we arrived at another ladder. Down again! All at once we arrived at another tunnel that turned from a black passageway into a small hall of beauty. The ceiling and walls were beautiful newly blasted white rock and imbedded in this were millions of tiny mica flakes which reflected our candlight like mirrors. Scattered over this area were larger chunks of mica, some black, ruby, amber or silver. It looked like a real fairyland. We sat down on the quartz and rock debris and slowly took in the beauty of it all. It was as quiet as could be, only the shadows moved.

Now the air was clear, the sound of drills or explosives was not to be heard

as the owner had kept the workmen on the surface until we had finished our tour. This was now a scene of beauty, but shortly it would become a hole filled with rock dust and cutting bits of mica that would slowly eat their way into the miners' lungs—for such are the lives of these men.

By this timc we had been underground for over an hour, but it did not seem that long. We had seen the mica sheets imbedded in the hard rock and had learned that one day this very mica would end in TV sets, rockets,, jets, irons, washing machines or any of the other countless electrical appliances.

Now began the long climb back up the mine shaft. We had to go a bit slower as we all carried small chunks of quartz flaked with shimmering snow-like mica.

Out in the sun the workers stood laughing as we blinked and shaded our eyes from the bright glare. Then single file, they took their supply of candles, walked to the pit, paused, put their hand to their forehead and asked the gods to protect them. Then looking at the bright green jungle and blue sky they descended into the mine. Only at sunset would they come back to the surface of the earth when the jungle began to dance with the shadows of kerosene lamps and the cries of the panthers and jackals replaced the songs of the birds.

These are humble, uneducated men, but without these men who live in a world of constant shadow, we would not have the technical equipment nor comforts of today's advanced civilization.

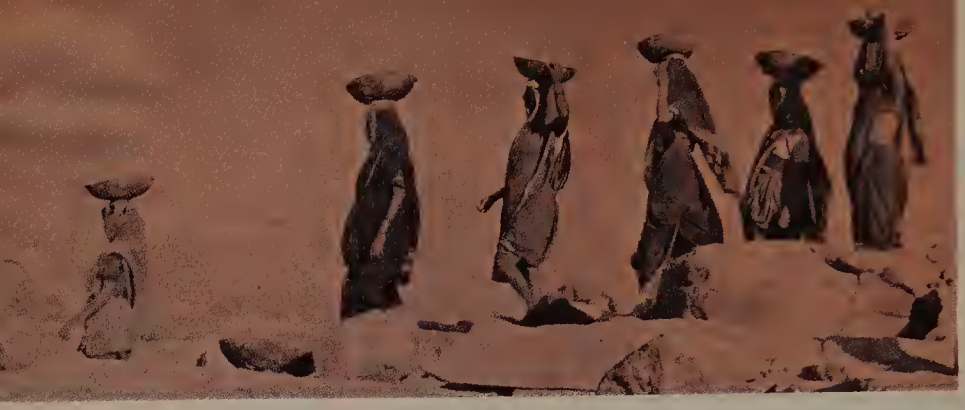
As we watched them file into the pit I could not help but think of St. Paul's admonition, "Can the head say to the hand—I have no need of you?" These are our people. these are our patients and today's civilization owes them a debt of gratitude. .

As the last of the fifteen heads disappeared into the shaft, we turned to go back to the jeep. The morning cool was now replaced by the warm dusty breeze that visits us until summer.

The trip back to the hospital was a quiet one, for each of us was absorbed in the thoughts of God's beautiful underground creation.

Medical Problems in Mica Land

SISTER M. LEONIE, M.D.



In the evenings, women line the roads to the mica factories, each with a basket of mica (split in between daily chores).

HOLY Family Hospital, Kodarma, is *really* located in the village of Chachai, midway between Kodarma proper and Telaya. Kodarma proper lies on the main road between Patna and Ranchi; this same road connects Patna to Calcutta. When the railroad station became a necessity because of the development of the mica mines, it was built about four miles from Kodarma proper. The name of the station is Kodarma, but the town which developed around it is known as *Jhurri Telaya*. Our Hospital therefore lies midway between Kodarma and Kodarma station or Telaya. It is roughly 100 miles from either Patna or Mandar Holy Family Hospital. The winding roads and fields dotted with palm trees remind one of the Flight into Egypt. Indeed many families today walk along these roads just as the Holy Family did then.

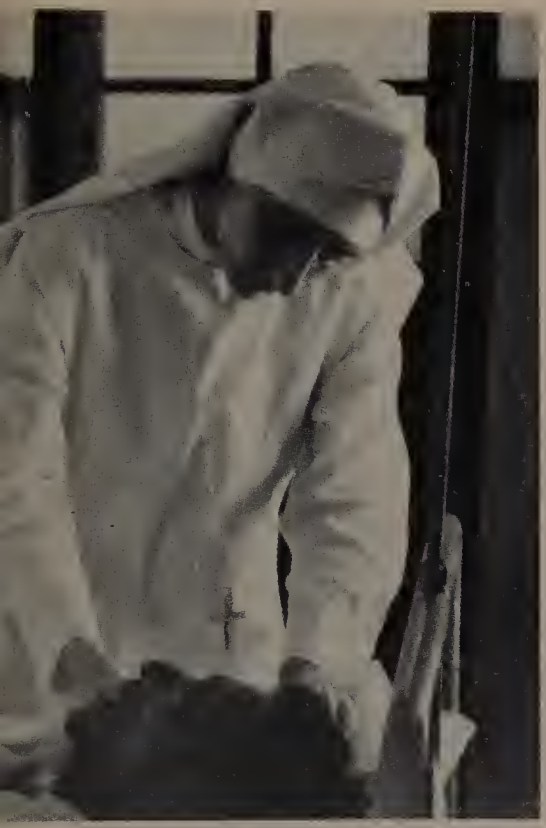
Kodarma is 1000 feet above sea-level. It is a hilly country. It looks as if, after God created the Kodarma area, He dropped a few hills here and there, just to beautify the rocky landscape and red clayish earth.

Greater Kodarma (Kodarma proper, and surrounding villages) has a population of about 200,000. The people are mostly rice farmers who earn a little extra by mica splitting. Naturally there are also the mica miners. There is no pharmacist or drugstore in Kodarma. Patent medicines are sold at the general store on market day. Wednesday is market day in Kodarma; and Sunday is market day in Telaya—then the villagers come from far and wide and the town appears to be very busy.

Kodarma's mica mines produce roughly 80% of the mica of the world. Mica is mined in both open and closed mines. It is found in large chunks which, because of their appearance, are called "books;" they look like closed books. For marketing purposes these "books" are split in layers, the layers being of a specified thickness. This is done by hand. A thin sharp knife blade is inserted and the mica split. The people here have acquired such a dexterity in doing this that no machine as yet has been able to match their manual performance.

In the morning one sees the men hurrying to the mica factories to work at sorting and storing. In the evening, the women line the roads to the factory, each with a basket of mica that she has managed to split, in between her other household chores. Gracefully each woman balances it on her head as she and the other women share the gossip of the day. Once at the factory (actually it is only four walls and a roof) she receives another basket load of mica that has been weighed. Receiving her wages she returns home to split this by the light of the kerosene lamp. This is not hard on their eyes, as all the women I have seen doing it are looking at their children, or someone else, while the razor sharp blade flashes back and forth without any conscious effort.

Besides Holy Family Hospital in Ko-



Tuberculosis is rampant in Kodarma. Inhaling the mica dust causes a condition of silicosis, or scarring of the lung. This condition leaves one susceptible to tuberculosis.

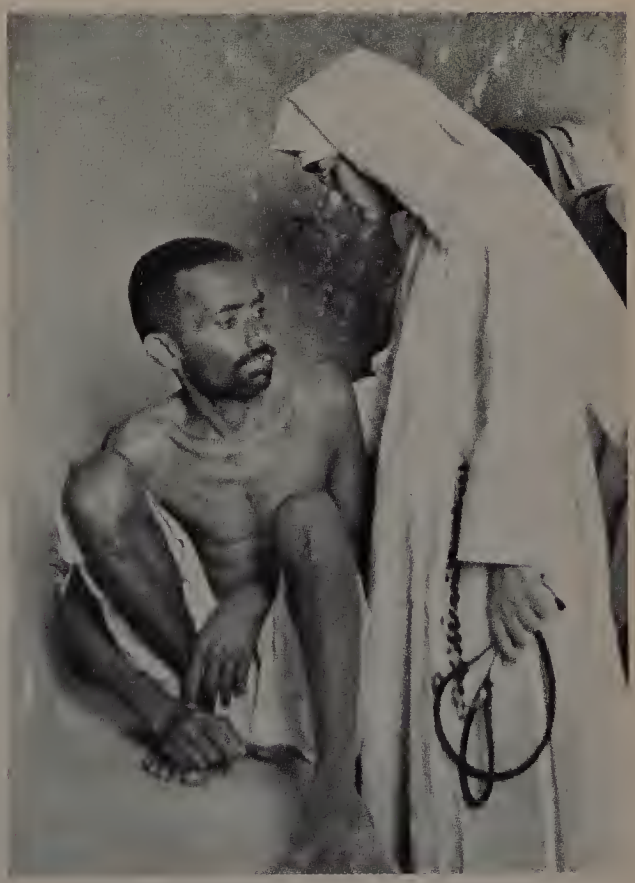
darma, there is a hospital for the mine-workers only, and a small government hospital. The total number of beds of these three hospitals is about one hundred, totally inadequate, for the area they cover. The next doctor or hospital is forty miles away.

Of all diseases. Tuberculosis and Avitaminosis are most rampant. The inhaling of the mica dust causes a condition of silicosis, a fibrosis or scarring of the lungs. On this silicosis, Tuberculosis is very easily superimposed. Here the incident is as high as 33%. There is a village near our hospital where there is no living adult male—all died of Tuberculosis superimposed on silicosis from working in the mines.

The story is much the same in each case. A young man goes to work in the mines, develops a cough, neglects it and comes down with Tuberculosis. He continues to work and infects his fellow workers. More often than not he dies in the prime of his life. The government has made strict regulations which the managers must meet to prevent the inhalation of mica dust. But the people don't seem to understand the necessity of following these measures.

Fortunately the new anti-TB drugs are a great help. We can now treat more patients on an ambulatory basis than ever before. Since our hospital is

T.B. The incidence here is as high as 33%. In one village near the hospital there is no living adult male—all died of Tuberculosis.



so small (about 30 beds) and has a heavy turnover of patients, we can not admit Tuberculosis patients. If they are in need of hospitalization we refer them to the Karma hospital which has 17 beds for TB patients! Otherwise we must treat them in the outpatient clinic. If the disease is not too far advanced it is truly remarkable how much we can accomplish in this way. Usually the patients are very cooperative and come regularly for their checkups. At times it is difficult to make them understand that they have to take medicine long after they have stopped coughing and feel well in order to prevent a relapse. Still, word is spreading that it is advisable to do what the doctor in Holy Family Hospital tells you to do and many come regularly.

The soil is rocky, yet along the rivers and elsewhere there are areas where rice will grow. It yields but one crop a year and here and there some pulses and grains. The result is that the normal diet of the people is lacking in vitamins and minerals. They suffer from marked avitaminosis. There are very few doctors so they do not get the vitamins any Indian doctor almost routinely prescribes. The result is that there are many diseases due to lack of vitamins, such as beriberi, pellagra, rickets, corneal ulcer and infections of the eye.

When I first came to Kodarma I was puzzled by the great number, relatively speaking, of tachycardia (fast heart beat). Some patients came in very much out of breath, almost gasping. As soon as I remembered that one of the symptoms of "dry" beriberi is a fast heart beat and prescribed massive doses of Vitamin B_1 with supportive cardiac treatment, they improved rapidly. Many children have been saved from total blindness by the timely administration of Vitamin A. All our postoperative cases receive adequate doses of Vitamin C routinely to aid in wound-healing. Cirrhosis of the liver (scarring of the liver) is fairly common around Kodarma. It is my private opinion that some of this can be attributed to the lack of vitamins in the diet. Also to a certain lack of proteins. The population is predominantly Hindu and therefore vegetarian. The only protein they receive is from rice and pulses, and that is not sufficient.

Speaking of livers—the ever-present amoebae, the *amoebae histolytica* to be exact, is also very much in evidence in Kodarma. Amoebic dysentery is as common here as elsewhere in India. Not being treated adequately, if at all. the amoebae spread and cause enlargement of the liver and liver abscesses. Large livers from almost any cause, are very common in Kodarma.

Hospital admissions show a larger number of tetanus cases than is usual in a hospital the size of Holy Family Hospital. Farmers cut themselves, children hurt themselves and do not bother to clean their wounds, or if they do clean them, and the wound happens to be the foot, as it so often is, it becomes infected with tetanus bacilli . . . In obstetrical cases. too, one finds so much tetanus.

In the winter—and the winter can be very cold in Kodarma—the thermometer registering near the freezing point in the early mornings—we get many burn cases. One way of keeping warm is to light a *chalamchi* (a small clay earthenware stove burned with coal) and put in under the bed or even wrap one's sari around it. The sari or the bedclothes catch fire easily and the burns are usually very extensive.

One man was brought to the hospital on straw in a bullock cart with third

degree burns all over his body except the face. According to the books he should have been dead three days before but he hung on to life. He was a poor man just trying to keep warm in bed when suddenly he woke up to find his bed and blankets in flames. There was nothing we could do for him except keep him comfortable. He lived for five more days before he died. We told his wife to be careful that the same thing would not happen to any of the other members of the family. Her answer was to the effect of "Which is better, to die of the cold or die of the flames?"

The hospital is two miles from the nearest town. There are no *debras* (motels) where the relatives may sleep. There *is* a kitchen where the relatives can cook meals for their patients! (Hindus will not take food from non-caste people.) In the dry season this is no difficulty. The whole family arrives and sets up housekeeping under the oleander trees outside the hospital compound proper, but still on the hospital property. In the evenings they sleep on the dispensary verandah. We do not discourage them, as it is a protection for the patients and the night-nurse. The situation has improved since the hospital was built. One night when I was called out to see a very sick boy I heard the rickshaw driver shout to another driver, "She could not have gone that way some years ago, before the hospital was built. I would not have come here then myself, it does make a difference."

Yes, a Christian hospital does make a difference in the area where it is located. One of the most consoling things I ever heard came from the lips of a wealthy mica mine owner. "Sister," he said, "you do not see, and you cannot see, but we do. When the women come to the hospital they see how the nurses keep their babies healthy and clean; they are thus taught how to do it and then slowly, they do it. *I* can tell you they do it. And what a difference it makes!"

Ready to go home. Sr. M. Th. Joseph and nurse escorting a patient and her baby to the rickshaw, Holy Family Hospital, Kodarma, India. The baby would have died if it had not been brought to the hospital.

INDIA'S FIRST PRESIDENT: DR. PRASAD

ON the evening of May 14, all of us from Holy Family Hospital, Kurji, who were home, as well as the nurses and aides, who were off duty, went next door to be among the crowd who welcomed ex-President, Dr. Rajendra Prasad, back to his old home at the historical Sadaquat Ashram (Birthplace of India's Freedom). Here it was that Mahatma Gandhi, Rajendra Prasad and innumerable others planned the freedom of India as a nation fifteen years ago.

Dr. Prasad was president of the constituent assembly after partition, and was president of India for two terms until his retirement on May 13 of this year. A lawyer, he gave up his practice in the cause of Indian independence, and was one of the founding fathers of Patna University and of The Searchlight, one of the leading newspapers of Bihar. His train arrived in Patna at 5 P.M. and a big welcome was held at the Gandhi Maidan (square) in town.

He arrived in an open blue car at 7 P.M. at the Sadaquat Ashram which was brilliantly lighted for the occasion. Sisters Adelaide, Bertrand and I were in the front row on the road, next to the military, who had kindly given us space. All along the road to the Ashram, the low walls were lined with little oil *deepas* (lamps) which flickered in the breeze. The welcoming platform was in the mango grove. The trees were covered with lights, like Christmas trees. Practically everyone wanted to garland this great man. Two of our graduate nurses, Aleyamma from Kerala and Sylvia from Ranchi, presented their garlands and greetings from us all. Except for the ladies of his party, we were practically the only women in the huge crowd. After the greetings, the president was driven to his old home. The new one is still under construction. At 79, he has earned his retirement.

Sister M. Frederic, Kurji
Holy Family Hospital, Patna, India

सत्यमेव जयते

India's first President, Dr. Rajendra Prasad greets Sister M. Alma, Medical Director of Holy Family Hospital, New Delhi. Dr. Prasad retired from the presidency on May 13th. A former resident of Patna, he knew the Medical Mission Sisters there.

INDIA'S NEW PRESIDENT: DR. RADHAKRISHNAN

A FEW years ago Medical Mission Sisters had the great honor of having President Sarvepalli Radhakrishnan speak at the laying of the cornerstone of Holy Family Hospital, New Delhi.

On that occasion Dr. Radhakrishnan said in part that though religion may speak through many dialects, its one authentic voice was compassion for humanity. To alleviate human suffering was to serve God. Religion would forfeit its name the moment it turned escapist and imagined that the worldly agonies of man were none of its concern . . .

The Medical Mission Sisters join the people of India in their congratulations and good wishes to the new President of India, Dr. Sarvepalli Radhakrishnan.

Congratulations to President Radhakrishnan. Sister M. Caroline, Administrator of New Delhi Holy Family Hospital, greets the new president. In the background, is the Rev. James Tong, S.J., of the Catholic Hospital Association of India.

A village midwife at work. Families must be educated to engage only trained midwives.

the GOOSE that SAVES BABIES' LIVES

SISTER M. LEONIE, M.D

"*Dudh na pita,*" (He does not drink milk).

With this remark an anxious father pushes a bundle of rags into the doctor's hands. Opening the rags a little, a grinning face of a newborn infant looks up. When a spasm involving the whole body follows she knows that the fears which were aroused by the father's first words are only too well grounded: it is a case of tetanus. The spasms of the facial muscles give the face this peculiar, and to the experienced, unmistakable grin. When the spasms involve the whole body the patient curves and seems to rest on shoulder and heels only—a distressing sight.

"How old is the baby?" This is a very important question because of the prognosis of the case. An infant of four or five days old who develops tetanus invariably dies. I know hospitals where they simply refuse to take in tetanus of the newborn if the infant is that young. When the newborn is seven or eight days old we can save roughly, fifty per cent of the cases. Ten, eleven, or twelve-day old babies have a hard struggle, but if we have the cooperation of the parents and the means, we can save all of them. The means are an important item, for tetanus is an expensive disease. One injection of 10,000 units of tetanus antitoxin costs Rupees 13—which is like $13.00 for them. The recommended dose for an adult is at least 50,000 units in the first twenty-four hours. We try to give the newborn 20,000 units daily. If one stops to think that many people earn only Rs. ½ (10¢) a day it is not surprising that most patients cannot afford the treatment.

The hospital does what it can, but so often after expensive treatment the patient dies anyway and one wonders if it would not have been better to spend this amount on a patient with a disorder who would surely recover. Our policy is to give if there is any hope, if the little patient then dies the parents have the consolation that everything has been tried.

Tetanus is a terrible disease. Just imagine having a charley horse extending all over one's body, without any periods of merciful unconsciousness. The patient remains conscious till the end. The cause of tetanus is the tetanus bacillus. These bacilli are found in the soil, especially in manured soil, since they are the normal inhabitants of the intestines of cattle. Any deep cut or wound contaminated with soil or manure is a source of infection with tetanus. Tetanus antitoxin administered soon after the injury is sustained will protect against tetanus. Our soldiers during the war were protected against tetanus by the administration of tetanus toxoid before going to battle.

The soil of India is heavily infected with tetanus bacilli. Cases of tetanus are not at all uncommon, not only in cases of accidents, cuts or wounds, but also in obstetrical cases and in the newborn. In the latter two categories, it is the midwife who is to blame. The untrained *dai* does not wash her hands before going to work, but only after the job has been done. The baby's cord is cut with a dirty knife or a sharp stone. Therefore if we get a case of tetanus of the newborn we give the mother antitoxin and vice versa. It is to make certain that the mother also receives her prophylactic antitoxin. If we tell her the baby is going to die and do not admit it, the chances are that the mother too will refuse treat-

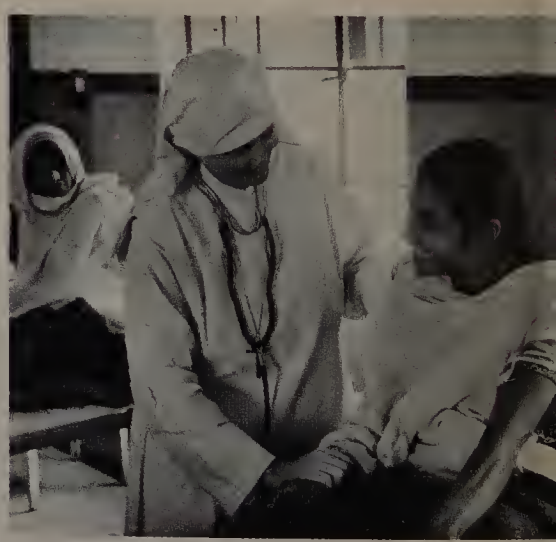
How old is the baby? asks the Sister-doctor. This is an important question in the case of babies suffering from Tetanus.

ment. More and more *dais* (native midwives) are being trained under successive Five Year Plans and there is improvement. Yet in rural areas such as Kodarma there are too many cases of tetanus in mothers or would-be-mothers and in newborn.

Recently we had a patient who had her fifth baby in the hospital. The first four of her babies had all died within twenty days of their birth of what appeared from her description to be tetanus. She was discharged from the hospital on the usual sixth day after delivery, but she refused to go. She did not quite believe our assurances that a baby born in our hospital was not going to get the disease. She remained 28 days in the hospital; she wanted to be sure this baby was going to live. Can anyone blame her after her previous experience?

Superstition also plays a role. A goose is brought into the baby's room. If the goose sits quietly and does not move the child will live. If, however, the goose flaps its wings and tries to get away, the child will die. I know of one missionary who keeps geese just for that purpose. If someone comes to borrow the goose, Father sends the Sisters after him to the house in order to try to talk the people into going to Holy Family Hospital for treatment. The geese are in frequent demand. Obviously the prevention of this disease lies in education. People need to be educated to come to the dispensary after injury for a prophylactic shot of tetanus antitoxin. This prophylactic dose of tetanus antitoxin is within most people's means. The families must be educated to engage only trained midwives. The midwives must be trained to give good care to mother and child. It all forms part of the Public Health endeavors which the Indian government is pursuing with all its might and in which Holy Family Hospital is happy to have a big share.

A cheerful patient admitted for an eye disease caused by malnutrition. Sister M. Leonie, M.D. (Kodarma).



One of the Smallest

SISTER M. CARMELA

SISTER, Does Kamla have her medicine? Sister, is the blood examination complete? Sister, has the injection been given? And, Sister, when does she have to return to see Sister-Doctor? You know I have to arrange the bus schedule to bring her.

It is 5:30 p.m. and this breathless string of questions is put to me biweekly by the bus driver in a khaki uniform. He takes the same interest in each and everyone of the 15 to 20 patients he brings from a forty to fifty mile radius to Holy Family Hospital in Kodarma, our hospital amidst the richest mica mines in the world with the poorest working conditions. While he checks each patient by name, passengers in his bus on the road are calling him to hurry, hurry and start. If they reach home by 8 p.m. they will be lucky.

Next week Kamla will tell me she is now worth six annas, the equivalent expression might be six cents; but the week she tells me she is now completely cured and worth rupees ten—ten dollars, she makes me feel as well as she expresses it.

Since most of the patients arrive at the hospital in bullock carts, this bus service is the most modern thing around Kodarma. Twice a week about two in the afternoon this kindhearted driver unloads his patients and takes the ordinary passengers on to the next town. Promptly at 5:30 p.m. he returns. When the patient feels that the condition will be serious enough for admission, the pots, pans, and fuel come along also. Occasionally even a milking goat retires to the little building in the rear of the hospital which will accommodate the relatives of patients.

One has to be really seriously ill to claim a bed in the little 30-bed hospital which, besides being the only Catholic hospital and dispensary, offers the only Chapel where Holy Mass is celebrated. The next church is one and a half hours' drive away, that is, if you have a good car—and none of these people even own a horse. Kodarma is not a one-horse town!

One morning the owner of the nearby mines and a friend of the hospital, telephoned asking the Sister-doctor to go on a home visit to see the wife of one of the mine workers. Since our hospital is a one-doctor hospital, Sister couldn't leave. As I am both nurse and midwife, I was the best substitute. A jeep came to take me into places where there seemed to be no roads but the driver was very confident that we were on a road. He was right, and we finally emerged on a wider path used by trucks coming from the mica mines.

The patient was a maternity case and definitely a doctor's problem. How to get the patient and the *charpoi* (string-bed) in the jeep? I took the bed and turned it upside down—the men of the household looked disgusted and protested: "That is not the way the bed stands up." I told them just as firmly that I slept in such a bed and knew how it stood. I picked up the bed and put it in the jeep—and it just fitted on the rear seat. The men looked—she did know something after all. Getting the patient from the *charpoi* to the stretcher was another problem we solved at the hospital.

In this hilly country water is a prob-

lem. The hospital is very fortunate in having a well and an electric pump—but the pump was stolen one morning at 3 a.m. while the dogs were locked up. The entire hospital staff had to carry water—each had a pail. All the relatives and patients converged on the well to wash clothes, clean teeth, take a bath, wash the baby. In the interests of Public Health *we* decided to carry water *for them* to the hospital. This went on for two weeks until we got a new pump.

Kodarma is the place to go if you wish to work with poor people. There are so many really *dihati*—poor and uneducated—yet so simple. One patient to whom I was trying to give an injection of emetine refused it in her arm because her complaint was in her stomach.

"Maybe the doctor doesn't understand where my sickness is," she said.

"Oh, the doctor knows."

"But why give it in my arm, not in my stomach, where the pain is?"

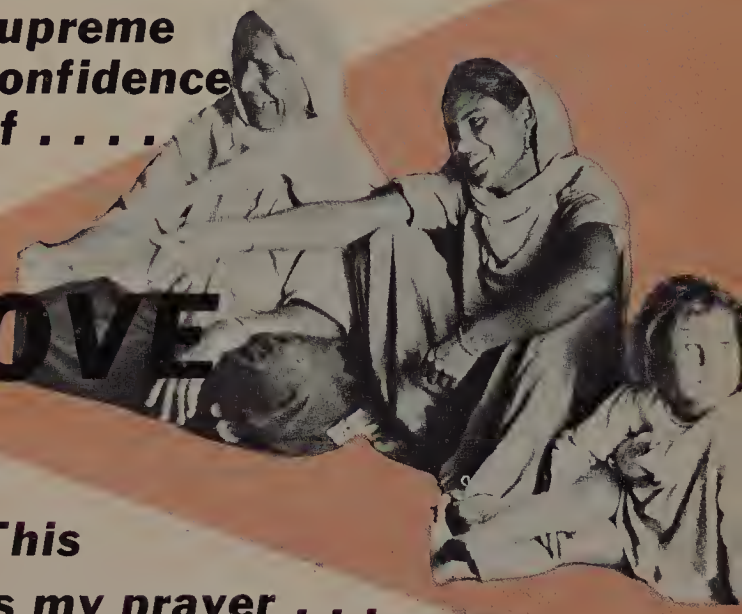
It took me sometime to convince her as she continuously offered her stomach, in between her blouse and sari. Then the idea struck me of making a drawing. I compared the blood to a train, and the heart a junction, and the medicine, a passenger, and the arm as one of the train stations, and the stomach another station. She understood what a train looks like, so I started my illustration about the blood that carries the medicine to the heart (junction) then goes to another station (stomach) and stays there to unload all the passengers including this injection. Oh, she enjoyed my illustration. Very well, she submitted to my injection cheerfully and not only that, she invited her friends to hear my illustration.

Explaining to the patients how to take their medicine is a big job. When and what to take with—hot, warm, or cold water, milk or tea, after or before meals; one minute or ten minutes apart, between the two tablets. Do I have to work after taking the tablets? etc. By the end of the day my head is dizzy answering so many questions. One patient was already out of the hospital gate, riding in a rickshaw and had to come back again because she forgot how to take her medicine; and her husband didn't understand my explanation! So there I was answering the same questions all over again.

As the mica from this corner of India, the largest producer in the world, may, depending upon the use to which it is put, determine war or peace, which nation first conquers space; Holy Family Hospital in Kodarma, although one of our smallest, is not the most insignificant.

Sister M. Carmela, nurse-midwife, seen here as she teaches nurses baby-care in the Public Health Center.

Give me the supreme confidence of . . . .



LOVE

This is my prayer . . . the confidence that belongs to Life in death, victory in defeat, to the power hidden in frailest beauty, to that dignity in pain which accepts hurt but disdains to return it.

R. Tagore—The Fugitive

The Medical Mission Sisters have as their apostolate the care of the sick in those parts of the world where the need is greatest. Theirs is a vocation that calls for a large measure of generosity from each individual Sister as she brings healing and hope to the people of India, Ghana, East and West Pakistan, Venezuela, and South Vietnam. Her task, whether as surgeon, nurse, pharmacist, technician, hospital housekeeper or secretary is one of bringing Christ's love to men in a tangible way through the action of her hands and the devotedness of her life thus making real the joyous message of salvation.

handy hindi

THE very handy language of India begins with a pun and ends with a puzzle. Of course, a number of things come in between, but the pun first. About a thousand years ago, when Alfred the Great (849-899) was saving the Christian Anglo-Saxons from the Vikings, there lived a poet in the north of India. This medieval poet's pun helped the Hindi language to be born. During some twenty centuries before he came on the scene, a lordly language which the learned called the "polished," or Sanskrit language, had been the language of literature, cornering the market, as it were. Then this poet came along and turned his back on the speech of court and temple and school, and in language only very slightly different from twentieth century Hindi he punned:

"Bisiyon ke sir kat liya,
Na mara na khun kiya."

Explaining puns is excruciating business, especially when they are international puns. Suppose we translate the rhyme with a rhyme and then give a word for word translation of the Hindi words:

See! I a score of them behead—
No one is hit, no blood is shed!

Bisiyon	*ke*	*sir*	*kat*
Twenties	's	heads	(I) having cut

liya,
took (off),

Na	*mara*	*na*	*khun*	*kiya*
Neither	(I) hit,	nor	blood	did (killed).

Going on doggedly with the explanation of the pun we call your attention to the Hindi words *na* and *khun*. They mean in English: nor blood. But write the words as one Hindi word and you have the word *nakhun*. And this word means nails, as of the ten fingers and ten toes!

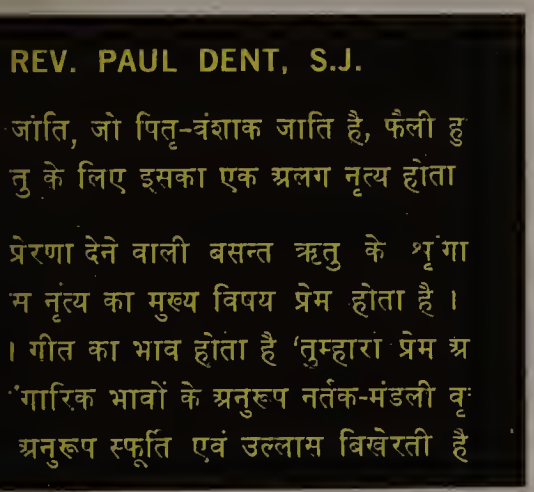
Hindi was born of Sanskrit and related languages around New Delhi in north central India, and for about a millenium has been spreading throughout the vast and very densely populated area west to Bombay and east to Calcutta. As a result, Hindi-speakers now number well over two hundred million or a good half of India's some half a billion population.

No one, or even, no two, of India's 14 major languages and 500 dialects has even nearly as many speakers as Hindi has. It is no wonder then that when India achieved independence on August 15, 1947 the popular choice for the country's national language fell to Hindi. But there has been opposition to this choice as India sees itself move further along the road of nationhood; and it may well happen that there will be two national languages in the country, Hindi and English, and the other languages of the land will live on in each one's particular area by private and even public endeavor.

Over and above the overwhelming number of Hindi-speakers, who are themselves just so many living arguments for making Hindi the national language, there is the argument that it is so easy to learn Hindi. For most Indian languages are of the Indo-Aryan family and are derived from or related to Sanskrit. Hence an enormous

amount of words are practically the same, in most Indian languages. This is true to a great extent, too, even of the non-Indo-Aryan languages of India, for instance the Dravidian-family languages and the Munda-family languages. All these languages use very many Sanskrit words, particularly words concerned with the religion, philosophy and culture of India's largest group, the Hindus, during most of the some 50 centuries of their traceable Indian history.

Not all Hindus, of course, know Sanskrit; but any Hindu who climbs the educational ladder as high as first high, sits down day after day and rattles off the amazing complexities of the "polished" language's *vyakarana* or grammar. In fact, if that *vyakarana* were not such a philogist's dream (or is nightmare the right word for it?), Sanskrit would itself be the logical choice for India's national language.



But just imagine half a billion people really talking a language with 8 cases, 3 numbers, 3 genders, 10 moods and tenses, 10 conjugations, 20 declensions, 36 rules of euphonic changes! Or did I drop one or two things in my counting? I do not know. I only know that there is no such thing as *Sanskrit sans tears*, and Hindi is *so* easy!

And now there are three other things to be understood about handy Hindi, Urdu, and Hindi literature, and the Hindi puzzle. Urdu comes first, and here is its story. During the Crusades (11th to 13th centuries) the Moslem world was marching both west and east, for their troops were fighting in India, too, and building up what was to be known from the 15th to the 18th centuries as the Moghul Empire. As their conquests widened throughout India their leaders experienced the need for a language which they could use conveniently to rule their Indian subjects. The Moslem power being centered in the Delhi area, they took the language current there, which luckily was Hindi, and soon they were calling it the language of their *urdu* or the language of their "camp."

This Hindi, which they called the Urdu language, they, of course, wrote in the Arabic letters which they knew instead of in the Sanskrit letters with which the Hindus wrote Hindi.

The Moslem speakers of camp Hindi or Urdu, of course, changed Hindi in another way. Being Moslems and not Hindus they naturally took many words out of their Arabic culture and used them in their Urdu, in place of words from the Sanskrit culture of the Hindus. However since the partition of India and Pakistan in 1947 the language of Urdu has changed somewhat.

If Shakespeare is the greatest name in English literature, the greatest name in Hindi literature is that of his contemporary, Tulsidas — most popular Hindi poet, author of Hindi's great epic poem, the *Ramcharitmanas* or, Pool of the Deeds of Ram. The Hindu deity Ram has his great story told so well in this lengthy poem that, leaving Shakespeare aside for the moment, we may say without exaggeration that, though there are many good poets,

there are only five great ones, in my opinion, Homer, Virgil, Dante, Tulsidas, and Milton.

And the Charles Dickens of Hindi literature is the frail very ordinary looking man with very ordinary looking mustache who looked at you with such kind eyes at crowded little Sarasvati Press, Benares. Before he died 30 years ago he had millions of readers of his many short stories and novels all over the Hindi world. Prem Chand wrote them, and it is hard to imagine a lover of Hindi not wishing to read Prem Chand stories.

It is hard to imagine any lover of Hindi not interested in another recent Hindi author, too, the late *Babu Shyam Sundar Das* of Benares Hindu University. A scholarly, rather than a popular writer, he was to bring Hindi to its twentieth century maturity. Something of the meaure of the man is told if he is called a combination of a Hindi Noah Webster, a Hindi editor of a Hindi Great Books Series and a Hindi Lord Macaulay all in one, tireless, scholarly author.

And Hindi has Catholic literature, too, and Catholic writers, thanks be to God! Only thirty-five years ago now a man found scarcely a dozen Hindi Catholic publications — mostly in not very good Hindi, too! Yet, the days of Catholic Hindi famine are gone forever, for the Hindi Catholic Renaissance is definitely here now! May it grow from strength to strength.

But Hindi ends with a puzzle, the Sanskrit alphabet. It is the easiest of India's eleven different alphabets, and that is one reason why six of India's languages use this alphabet, Hindi, Nepali, Oraon, Marathi, Gujarati, Sanskrit. Sanskrit has 13 vowels, but Hindi uses only 11, plus Sanskrit's 33 consonants. That gives Hindi 44 letters a number that is really smaller than English has in its Roman alphabet. For most of the 26 letters in English are pronounced and written three ways: capitals, printed and written. Three times 26 is considerably more for a beginner to learn that Hindi's forty-four letters, for Hindi has no capital letters and no difference between the printed letter and the written letter. And, best of all, each Hindi vowel has only one sound, not forty-eleven sounds as so many English vowels have! Thus the Hindi *short a*, the first vowel and first letter in the alphabet, is pronounced as in attend and only as 'a' in attend and always as 'a' in attend, and so on for the other vowels and consonants.

Meanwhile, *Parameswar ap ko sada pyar kare*, or God (Parameswar) you (*ap ko*) always (sada) love (pyar) may he do (*Kare*). Translate as "God love you forever" and pronounce as *Purruh-mayswurr ahp ko suddah peeahr kurray*. Thank you for letting me give you your first Hindi lesson.

YOUR WILL

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $..... for its purposes,"

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.

BOOKS

THE CHURCH & THE WORLD

AFRICAN ENCOUNTER. Robert Collis. N.Y. Scribner. 211 pp. $4.50.

Dr. Collis writes of his experiences as Head of the Pediatric Department of the newly established University College of Ibadan in Nigeria. His impressions of the country and the people, his reactions to the medical situation and the almost superhuman efforts required of government and private groups, his warm and vital response to all he met, all combine to make this an interesting and compelling book. While admitting to bad as well as good impressions, his enthusiasm for the new nation is not dampened. In his conclusions he puts forward a very realistic and hopeful program for the medical development of Nigeria.

MARYKNOLL FATHERS. Glenn Kittler. Cleveland. World Pub. 318 pp. $5.00.

The success of Mr. Kittler's earlier book *The White Fathers* leads one to expect more of the same. Many of the same elements are found here, the fine character delineations, the fast moving style. The earlier years of Maryknoll are recounted with zest. The spread of the community is told by means of tales of various missioners. While the stories give mission flavor, they break up the continuity of the whole. Despite these drawbacks, the book is a *must* for mission libraries, and should be well received by many readers.

GOLDEN BOATS FROM BURMA. Gordon Hall. Phila., Macrae Smith. 255 pp. $3.75.

Adoniram and Ann Hasseltine were 19th century New England Protestant missionaries to Burma. While Adoniram concentrated on preaching and Biblical translating, Ann worked with the women and children, winning a place in their hearts. This is the warm and loving tale of their missionary career.

THE SANDS OF TAMANRASSET. Marion M. Preminger. N.Y. Hawthorn. 279 pp. $5.00.

In the years since his death, there has been considerable interest in the life of Charles de Foucauld, soldier, explorer, hermit of the Sahara and spiritual father of the Little Brothers of Jesus. This latest book follows the traditional line of biography, tracing the steps of Foucauld from his spoiled childhood in an aristocratic French family to his death in the Sahara. Respect and admiration for Foucauld are obvious throughout the book. Miss Preminger avoids, however, asking some of the questions which must be asked when viewing so complex a personality. The simplicity and clarity of the style, as well as the comparative brevity of the study, will recommend it for High School collections.

THE NATION THAT REFUSED TO STARVE. John W. O'Daniel. N.Y. Coward-McCann. 121 pp. $2.75.

The heroic struggle of South Vietnam to rebuild itself after years of war, a division of the country, and mass migrations from the Communist controlled north, is told by the former Chief of U.S. Military Assistance Advisory Group in Vietnam. The many fine photographs help to tell the story graphically.

SISTER M. FABIAN

across the

VENEZUELA

Island for Leprosy Patients

On the occasion of our stopover in Maracaibo on the way home from vacation about eight of us went on a little expedition in a launch on Lake Maracaibo. The most interesting place we saw, and where we spent most of the time, was the *Isle de Providencia*, an island for victims of leprosy maintained by the public health service. Our Maracaibo Sisters had some gifts for the chaplain, but he was not there at the time, so one of the doctors took us on a tour. He could not have been more obliging, nor had a more sincere and human interest in his patients. We met several doctors and a number of the aids, and they all impressed us the same way. Most unfortunately, they do not have graduate nurses, as the salary the health service pays is very low. The buildings were begun at the bequest of Bolivar himself, and were completed in 1829. They are of concrete, very high-ceilinged, large and numerous. The island staff keeps up the repairs admirably, but still the buildings cannot help but show their age. We saw only the hospital buildings and the chapel, which took us from two to three hours.

For Sister Juanita and Sister Samuel it was their first visit to the island in five or six years, and they were both very much impressed by the improvements in conditions and atmosphere. The grounds have been cleaned and landscaped simply but nicely, and modern facilities are slowly coming in. The week we were there the Shell Oil Company had just completed laying a cable which was to bring electricity from Maracaibo. Until now they have had to rely on their own rather makeshift plant and have had an unsteady current for twelve hours a day. The next improvements on the agenda are water and telephones; trade-training, and handicraft work — occupational therapy. After that they hope to find some way of securing or making artificial limbs.

Apart from the interest of the Medical Staff, probably a large part of the improved attitudes of the patients is the success of the sulfone drugs. Now a patient who arrives there is not doomed to die, and there have been many discharges in the last few years. Nor must a patient wait until he is cured, to be discharged. He only needs to be controlled. Of course it may take years to get the patient under control, but eventually they do find the right medicine and the right dosage for each particular patient, and then he is sent home and put under the surveillance of his local public health service. But I should not paint too rosy a picture either. There are still many patients who will never leave. We met one woman who has been there for 45 years. She has only stumps for legs, very withered arms, although she is not yet 60 years old. There were many others in varying degrees of incapacitation. And the Staff, for all their good will, do not have much with which to work. How we wanted to stay and help them!

medical mission world

The doctors are naturally very much interested in leprology research. The doctor who took us around knew about our Sister Francis' work in Ghana and had read some of her articles in the leprosy journals.

Sister Marion, Sagrada Familia Hospital, Judibana, Venezuela

VENEZUELA

Epidemic of Measles

There was an epidemic of measles among a group of 100 Motilone Indians. They had gone out in search of food and somewhere along the trail measles joined them, and then they went looking for medical aid. They were brought into Machiques mission and housed in a shed. The Sister-nurse from the Machiques mission was helping care for them, and the government also. Fifteen had already died by the time we got there. We were out on a trip to the area when we heard of it.

We offered to take three sick Motilone babies back to the hospital in Maracaibo with us. We ended up with four. Each of us, except Sister M. Joseph who was driving, had one in her arms. All had measles plus bronchial pneumonia. One of them looked as if he would die along the way, but he managed to live one day after he arrived at the hospital. He is enjoying the Beatific Vision by now; but the others, if they are lucky, will return to the mission; if not, they will go back to life in their own tribe, with almost nothing to sustain them.

The land of the Motilone and the Yucpas Indians is very fertile and greatly desired by others, but they are so poor and have so many difficulties. . . . On the walk we took, we met the wife of a dead Indian chief and heard the whole story. The Capuchin Fathers have done a great deal towards changing some of the non-Christian customs of the Yucpas tribe. One custom is that the wife of a man who is killed, must hang herself. The same custom dictates that if a wife has been unfaithful and goes off with another man, her husband must hang himself. But they still chastize the unfaithful woman by beating her on the head and hands with a bow. Since the bow is very sharp and the force used is great, many stitches are needed to close up the wounds. We saw one woman whose wounds were healing. The Sister nurse at the dispensary had taken care of her.

Sister M. Zita, Coromoto Hospital, Maracaibo, Venezuela

WEST PAKISTAN

Photos a la carte

One afternoon at Holy Family Hospital, Karachi, I met a group of young girls on the second floor. They were shyly edging their way toward the Chapel. I pointed out the statue of Our Lady to them. However, as my Urdu is not what it could be, I was delighted when one of my little tray-girl friends happened along. In fluent Urdu she pointed out the crucifix and showed them the picture of *Jesu*, *Miriam* and *Yusuf*.

Then I asked her to ask them if I might take their picture. They agreed and we went to the front steps of the hospital. I was happily taking photos when a gentleman wearing a red fez approached. He was the grandfather and asked for what purpose these pictures were being taken? I told him I would like to show them to my friends in America. He seemed pleased and said he would like a copy also. Then the father of the children appeared. He also would very much like a copy of the picture and would I please go into the hospital and take one of his new-born baby? I did get the picture of the new-born baby with its mother. I was amused when Sister M. Ruth told the mother I would like to take a picture. She noticed it was going to be a flash photo, so she pulled out her colored glasses!

Sister M. Daniel

SOUTH VIETNAM

Celebration for the Martyrs

At the end of February the Vietnamese Catholics celebrated a triduum in honor of the 100th anniversary of the martyrdom of 1,000 Vietnamese Catholics and a French missionary Bishop, Bishop Cuenot. The celebrations included a trip into the countryside past bright green rice fields (not quite ripe for the harvest) and bamboo groves, through small hamlets of straw homes with sleeping babies swinging in hammocks, past more rice fields, banana trees, pineapples, mangoes . . . it is a beautiful and rich country . . . our destination? Go Boi, a village 15 miles or so from Quinhon and the home of Blessed Madeleine Huynh Thi Luu. During the persecution 100 years ago she won the palm of martyrdom for assisting Bishop Cuenot in hiding from his persecutors.

All the people of Go Boi turned out in their best attire, lining both sides of the road leading to the church about three city blocks away, to greet Bishop Chi (our Bishop) who came to celebrate an outdoor Pontifical Mass for the occasion. Bishop Seitz from Kontum was also present. (He is one of the few remaining French bishops in Vietnam. His diocese is in the mountainous area of Kontum with nearly 90,000 Montagnards. The Communists are quite active there.) The little school girls lining the road were dressed in white robes with cloth-made flower bands for their heads. Next came the women. Then the parish band consisting mostly of drums. Last of all came the parish elders dressed in their ceremonial blue tunic and black headdress. The people really go all out in decorating for ceremonies of this kind. All followed Bishop Chi to the altar set up outdoors for Mass and Benediction. Bishop Chi used the chalice which belonged to Bishop Cuenot. As it was an afternoon Mass. by the time it was finished, the sun had set and it was getting dark so we had to hurry back to the hospital.

Sister M. Germaine, Holy Family Hospital, Quinhon, S. Vietnam

Time out for a little mountain climbing in Darjeeling. (l to r) Sr. M. Frederic, Sr. M. Joan, Sr. M. Michele.

Amman, Jordan. On Sunday, May 20, His Majesty, Jabal Hussein, King of the Hashemite Kingdom of Jordan, in the presence of over 1500 dignitaries and guests, cut the green and white ribbon and officially opened the Muasher Memorial Hospital. Among the speakers at the ceremonies were: the Prime Minister, the Speaker of the House, the Minister of Health, and the vice-president of the American University of Beirut. Dr. Sa'ad Muasher, Medical Director of the hospital, was decorated on this occasion by the King with the Order of the Star.

The 127-bed hospital is owned and was built by the Muasher family as a memorial to their father. Seventeen Medical Mission Sisters from England, United States, Holland, and India staff the hospital, with Sister M. Elise, M.D. as administrator and Sister M. Victoria, as superior.

On May 22nd the Official Blessing of the hospital was performed by the Patriarch of Jerusalem, His Excellency, Archbishop Albert Gori, with representatives from all religious orders present.

R.i.p.

Please pray for our benefactors recently deceased:

Most Rev. Joseph Gilmore, S.T.D.,
Helena, Mont.
Rt. Rev. Msgr. James J. Flannery,
Queens Village, N. Y.
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receives the world in him. Only the being whose otherness, accepted by my being, lives and faces me in the whole compression of existence brings the radiance of eternity to me.

Martin Buber

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